

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06702

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Dorchester</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddville</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>No</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Abbott</b>				<b>4. DATE OF DEATH</b> Month <b>76</b> Day <b>1</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7/4/1877</b>		<b>9. AGE</b> (In years last birthday) <b>81</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Seafood</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Deals Island, Md.</b>			
<b>13. FATHER'S NAME</b> <b>George W. Abbott</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisa Webster</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>No</b>		<b>17. INFORMANT</b> Address <b>Thurman Abbott, Toddville, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) Coronary occlusion</b>  <b>420.1</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____            _____ DUE TO (c) _____         </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>1 day</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> 		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>6/1/59</b>			
<b>EXAMINER'S NAME (Type)</b> <b>John Mace Jr.</b>							
<b>22a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>JUNE 3, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ZION CHURCH CEMETERY</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>LECOMPT FURNAL SERVICE</b>				<b>24a. REC'D BY REGISTRAR</b> <b>JUN 3 59</b>			
<b>ADDRESS</b> <b>CAMBRIDGE MARYLAND</b>				<b>24b. REGISTRAR'S SIGNATURE</b> 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

6727 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Caroline</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>7 yr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>S.S. State Hosp.</b>		d. STREET ADDRESS <b>Federalsburg 05X-2</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Adams</b>		4. DATE OF DEATH Month <b>6</b> Day <b>- 28</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/67</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sawmills</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Adams</b>		14. MOTHER'S MAIDEN NAME <b>Belle O'Brien</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Records S.S.H. Camp</b>		Address <b>Records S.S.H. Camp</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>903.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 days</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Proton Terminal</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell to floor in dining room</b>	
20c. TIME OF INJURY Month, Day, Year <b>4-23-59</b> Hour <b>12-15</b> P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home at Camp</b>		20f. (City or town) <b>Caroline</b> (County) <b>Caroline</b> (State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		22d. LOCATION (City, town, or county) <b>Hurlock</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry E. Darby Seaford</b>		ADDRESS <b>Seaford</b>	
24a. REC'D BY REGISTRAR <b>JUL 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Death: *Jan 15, 1950*

5. Place of Death: *Home*

6. Cause of Death: *Myocardial Infarction*

7. Manner of Death: *Natural*

8. Signature of Medical Examiner: *Dr. J. H. Smith*

9. Date of Signature: *Jan 16, 1950*

*John Doe*  
*Myocardial Infarction*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6711

Items 8 & 9 Film G244 7/8/59 cap  
 Item #14 - Film G244-7/10/59-mb

## CERTIFICATE OF DEATH

06704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>OAKLEY STREET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 CAMBRIDGE</b> d. STREET ADDRESS <b>1 OAKLEY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>BARKLEY</b> Last 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>19 59</b> 8. DATE OF BIRTH <b>7/11/1876</b> 9. AGE (In years last birthday) <b>81 82</b> yrs. 10. AGE (In years last birthday) <b>81 82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>DRY GOODS STORE</b> 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM F BARKEEY</b> 14. MOTHER'S MAIDEN NAME <b>AMANDA RUARK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>214 07 7653</b>		INFORMANT <b>MRS ELLA WALTER</b> Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Arteriosclerotic Cardio-renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 23, 19 59</b> to <b>June 30, 19 59</b> , that I last saw the deceased alive on <b>June 30, 19 59</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>6 Church St. Cambridge, Md.</b> DATE SIGNED <b>6/30/59</b>	
PHYSICIAN'S NAME (Type) <b>John Mace Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEM. PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b> ADDRESS <b>CAMBRIDGE MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6712

CERTIFICATE OF DEATH

09027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore St. Hosp.</u>		d. STREET ADDRESS <u>05x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>-</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1st 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Lancashire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN Vernon Hood</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Eastern Shore State Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>sev yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Br. Syndrome assoc. with simple Br. d. with Agy.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>59</u> , to <u>6/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>7:14 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D.		ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Simon Virkutis, M.D.</u>		DATE SIGNED <u>6/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Preston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u> ADDRESS <u>Corral Eastern Md</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

DO NOT WRITE IN THESE SPACES  
 FOR OFFICIAL USE ONLY  
 DO NOT WRITE IN THESE SPACES  
 FOR OFFICIAL USE ONLY

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____	
SIGNATURE OF WITNESS _____	
SIGNATURE OF DECEASED _____	
SIGNATURE OF NEXT OF KIN _____	
SIGNATURE OF SURVIVOR _____	
SIGNATURE OF BURIAL OFFICIAL _____	
SIGNATURE OF INTERMENT OFFICIAL _____	
SIGNATURE OF FUNERAL HOME _____	
SIGNATURE OF CEMETERY _____	
SIGNATURE OF CHURCH _____	
SIGNATURE OF OTHER _____	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06705

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>62 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>			d. STREET ADDRESS <b>Edlon Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Buena Brinsfield Cook</b>			4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1888</b>		9. AGE (In years last birthday) <b>70</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Brookview, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Thomas Brinsfield</b>			14. MOTHER'S MAIDEN NAME <b>Harriett McAllister</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Brinsfield Cook, Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO (b) <b>Fracture neck r. femur.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9040</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 Min.</b> <b>10 days.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home</b>			
20c. TIME OF INJURY Month, Day, Year <b>9 AM 6-18- 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
		20f. (City or town) <b>Cambridge</b>		(County) <b>Dor.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/29/59</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem.</b>	
				22d. LOCATION (City, town, or county) (State) <b>East New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leunith L. Shoups</i>		ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6714

CERTIFICATE OF DEATH

06706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salem</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Davis</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19, 1953</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Claudel Davis</u>			
14. MOTHER'S MAIDEN NAME <u>Agnes Sampson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Claudel Davis, Salem, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>108X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Autopsy findings compatible with Rickettsial Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>6-7-</u> , 19 <u>59</u> , to <u>6-14-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-13-</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hilton H. Wilson</u>				ADDRESS (Street, city or town, state) <u>232 Cedar St. Cambridge, Md.</u>			
DATE SIGNED <u>6-19-59</u>				PHYSICIAN'S NAME (Type) <u>Hilton M. Wilson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard W. S. Clark</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>							

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8591

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09029

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>2 Talbot Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ellen</b> Last <b>Dyott</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>		9. AGE (In years last birthday) <b>87 2</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Covey</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07 3359</b>		17. INFORMANT <b>Records E.S.S. Hospital- Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>due to</b> (c) <b>due to</b> (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>6/27/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hines</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate and forward it to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 4 should be forwarded to the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





6728

## CERTIFICATE OF DEATH

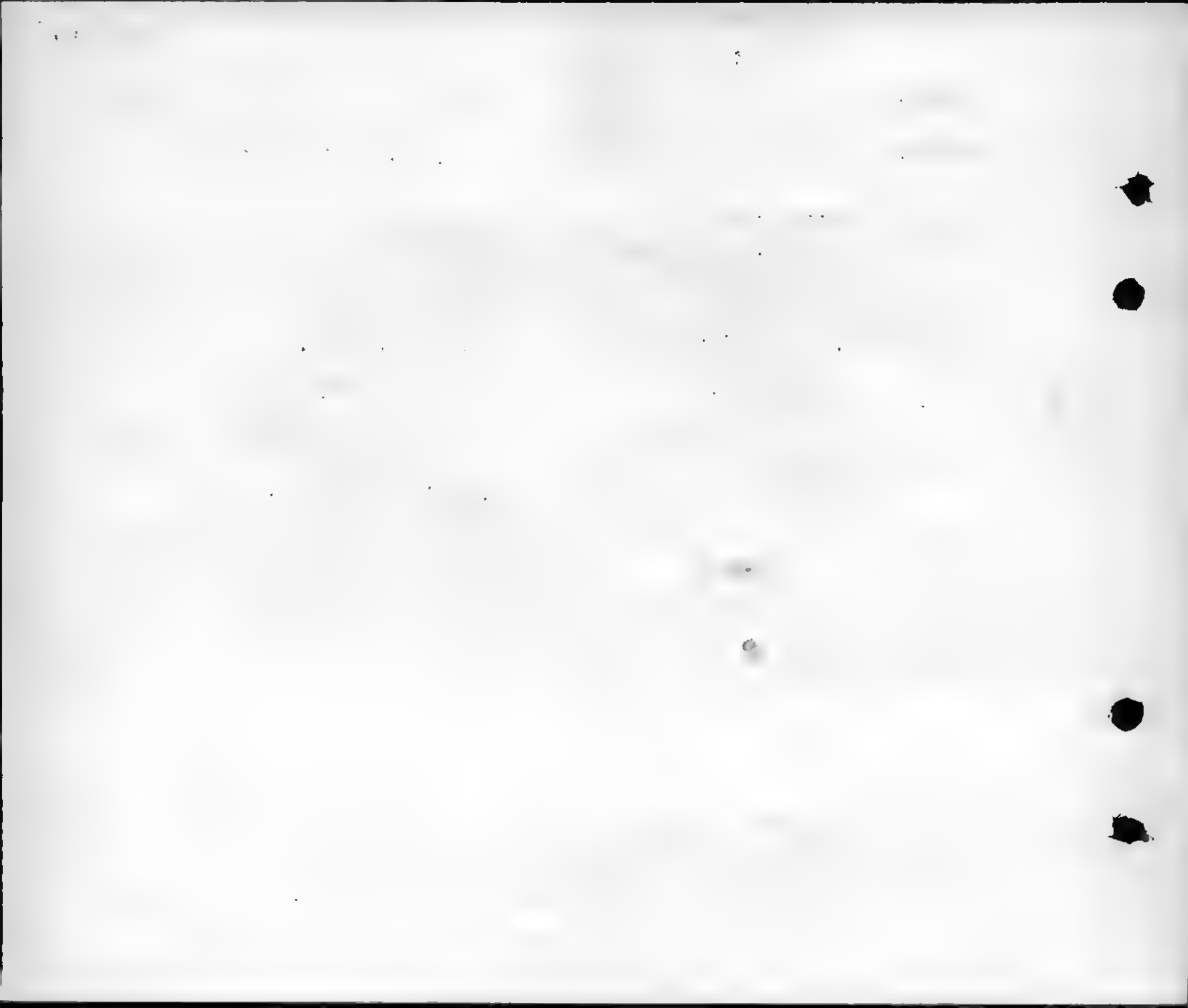
06707

Reg. Dist. No.

1. PLACE OF DEATH a. <b>CORCORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE R F D # 3</b> c. LENGTH OF STAY IN 1b <b>5 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE R F D # 3</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>CORDEIS</b> Last <b>ECKEL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>19 59</b>			
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 27 1887</b>	9. AGE (In years last birthday) <b>72</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES MGR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CORP</b>		11. BIRTHPLACE (State or foreign country) <b>PITTSBURG PENN.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ANDREW ECKEL</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE B ECKEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		INFORMANT <b>MRS J C ECKEL</b> Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PARKINSON'S DISEASE</b> DUE TO (c) <b>1</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>3 Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Mon 17, 1959</b> , to <b>June 23 1959</b> , that I last saw the deceased alive on <b>June 16, 1959</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b>		M.D. <b>136 Race St</b>		DATE SIGNED <b>6/24/59</b>	
PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>		<b>Cambridge, Md</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 25 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST JOHN CHURCHYARD</b>	
22d. LOCATION (City, town, or county) <b>CONERSVILLE</b>		22e. (State) <b>MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPTE FUNERAL SERVICE</b>		ADDRESS <b>CAMBRIDGE MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Harris</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



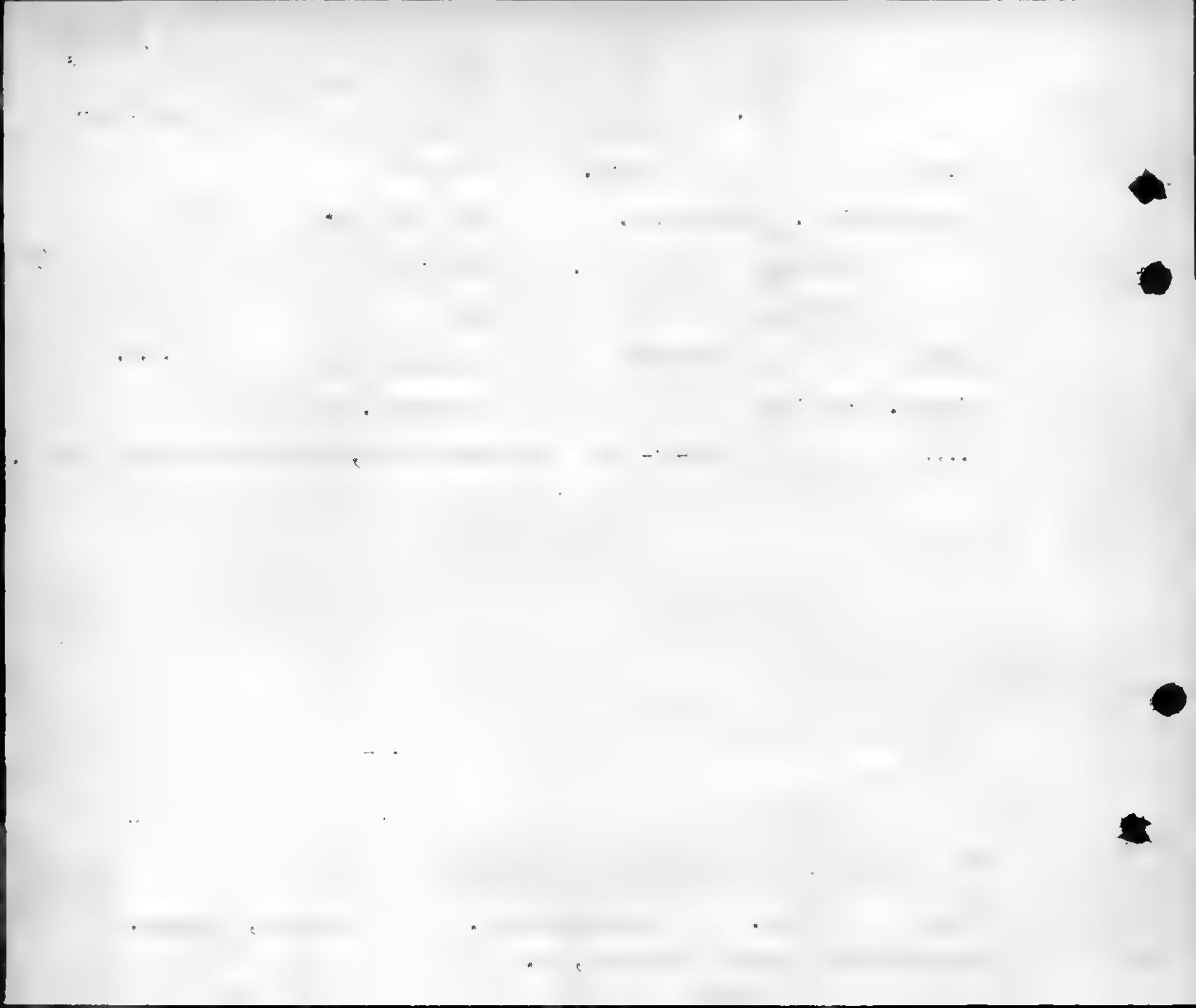
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

06708

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>5 Years.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		d. STREET ADDRESS <b>Belvidere Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Hospital, Cambridge, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ARTHUR D. GREENFIELD</b>		First Middle Last		<b>4. DATE OF DEATH</b> Month <b>6</b> Day <b>9</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1884</b>	
<b>9. AGE</b> (In years last birthday) <b>74</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Salesman</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Evan A. Greenfield</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline E. Dean</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>469-18-5642</b>		<b>INFORMANT</b> <b>Mrs Betty Janson, 3316 Gilmore Terrace, Balta.</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aneurysm of the Aorta</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from 5-8-59, 19, to 6-9-59, 19, that I last saw the deceased alive on 6-9-59, 19, and that death occurred at M, from the causes and on the date stated above</b> ADDRESS (Street, city or town, state) <b>200 Maryland Avenue</b> DATE SIGNED <b>5-12-59</b>							
<b>ACTUAL SIGNATURE</b> <i>Albert E. Bunker</i> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <b>Albert E. Bunker, M. D.</b> <b>Cambridge, Maryland</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>22b. DATE THEREOF</b> <b>6/12/59.</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenmount Chapel.</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Le Compte Funeral Service, Cambridge, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>JUN 15 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After it is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

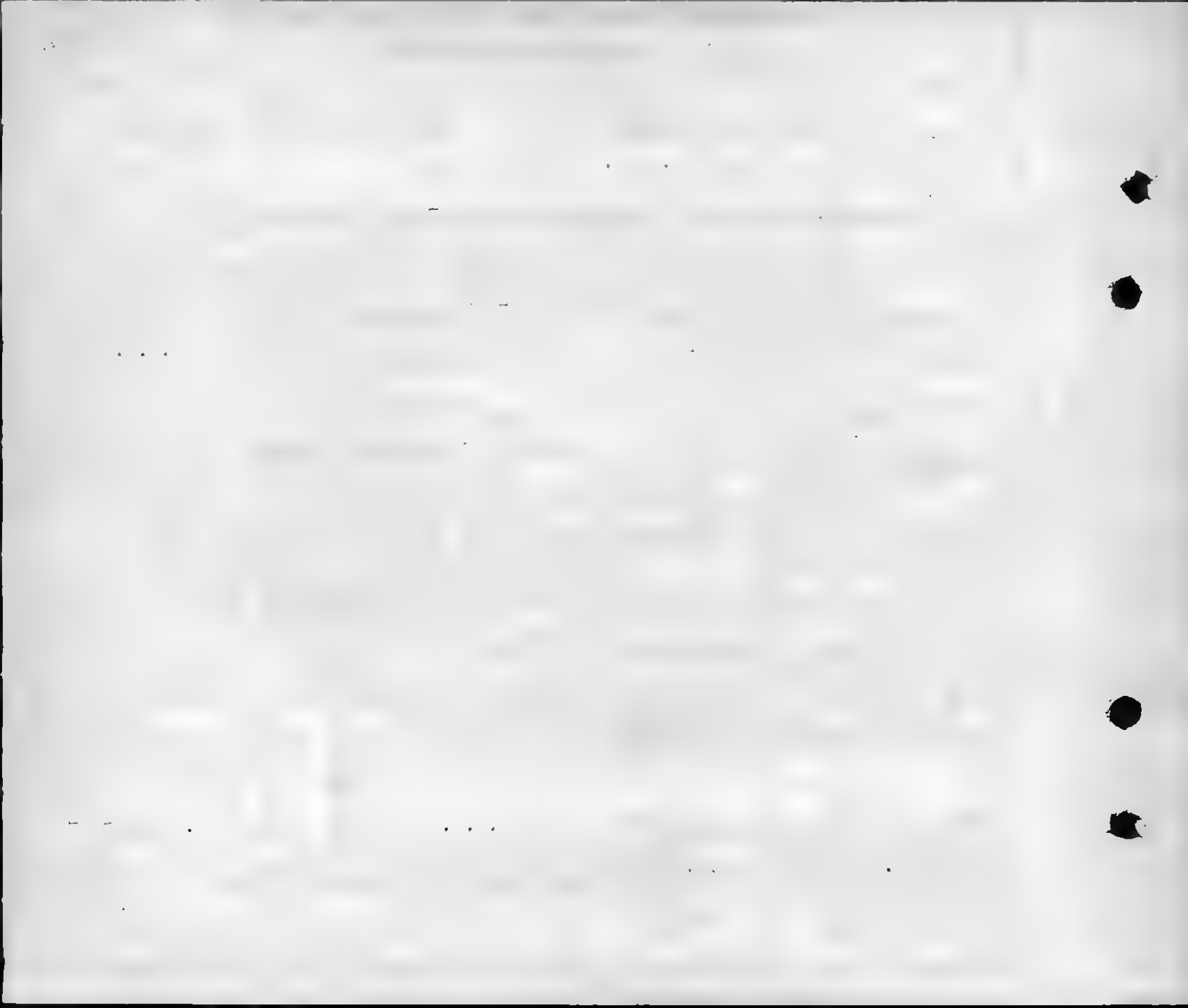
## CERTIFICATE OF DEATH

Reg. Dist. No.

06709

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>8mo.6das.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>---</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Marie</u> Last <u>Holmes</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-87</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William HOLMES</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiovascular Disease</u> DUE TO (c) <u>General Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 11, 1958</u> , to <u>June 17, 1959</u> , that I last saw the deceased alive on <u>June 17, 1959</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. DeFilippis</u>				ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. DeFilippis, M.D.</u>				DATE SIGNED <u>6-18-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>6-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Talbot Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harley Farn - 6 Home-Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6716

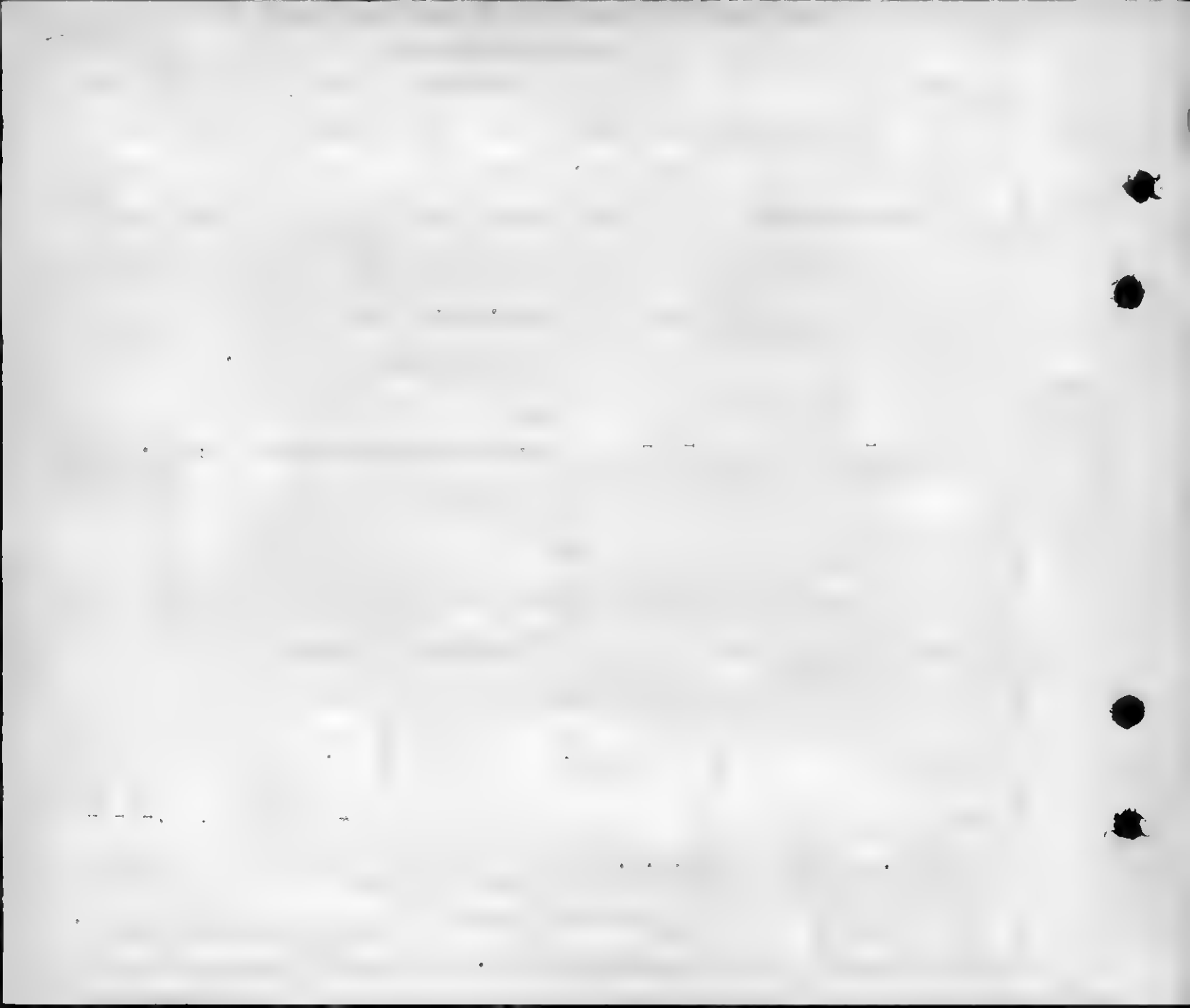
## CERTIFICATE OF DEATH

06710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Howard</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1899</u>	
9. AGE (In years last birthday) <u>59</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Howard Hopkins</u>			
14. MOTHER'S MAIDEN NAME <u>Wilsie Cornish</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>218-03-6888</u>				17. INFORMANT <u>Mrs. Mary Hopkins, Hurlock, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 29, 1959</u> , to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>6-5-59</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Seltman</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>June 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



06711

CERTIFICATE OF DEATH

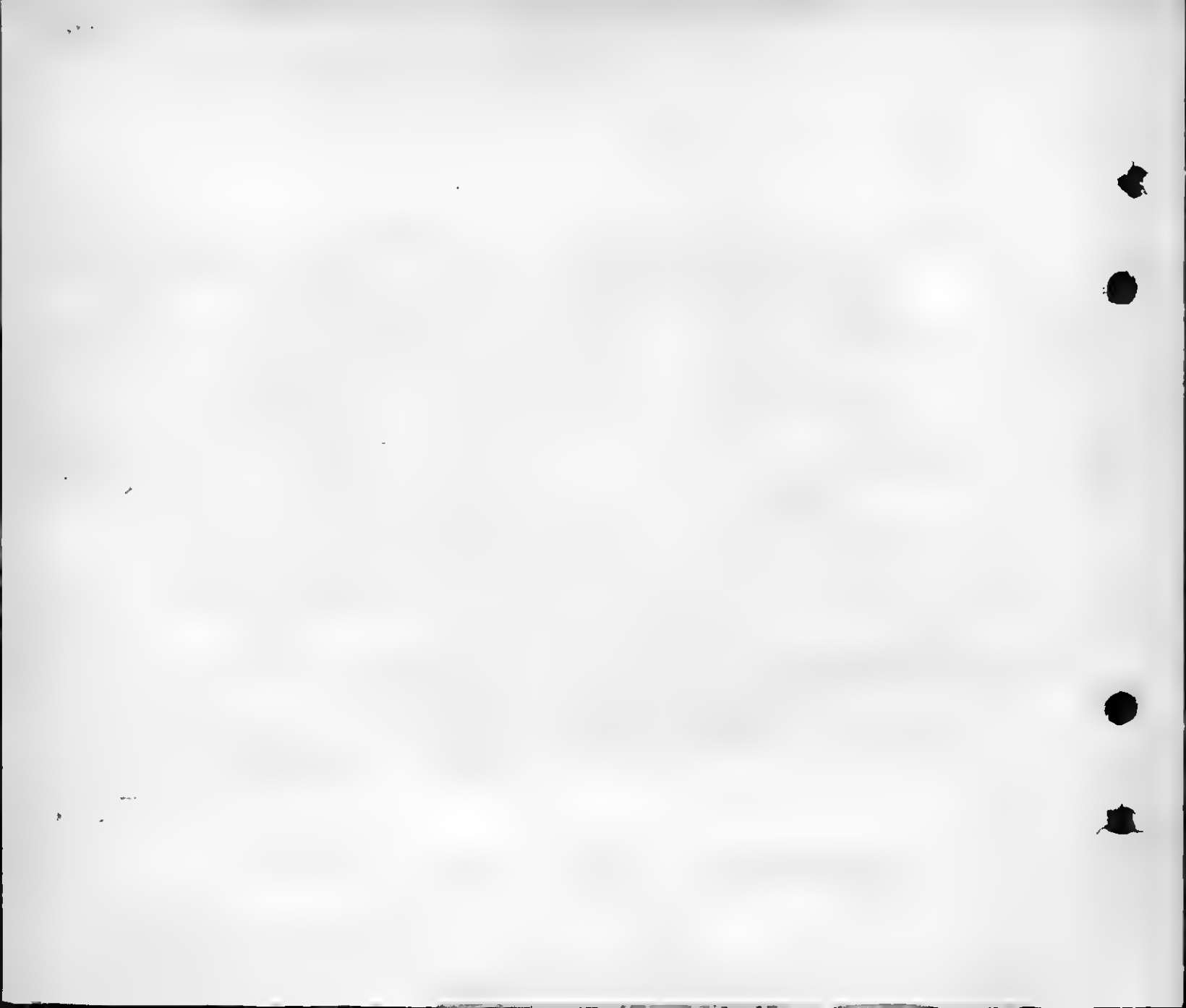
6730

Reg. Dist. No.

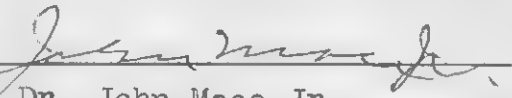

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colliotts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colliotts</u>	
c. LENGTH OF STAY IN 1b <u>All life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Riley</u> First <u>Horseman</u> Middle <u>-</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/29/1870</u>
9. AGE (In years, last birthday, yrs.) <u>89</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boatman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Boat</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Horseman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>MISS LUTIE HORSEMAN, Colliotts, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR RENAL DISEASE</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 YEARS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>27 APRIL 1950</u> to <u>13 JUNE 1959</u> , that I last saw the deceased alive on <u>3 JUNE 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter E. Gunby</u>		ADDRESS (Street, city or town, state) <u>105 CHURCH ST</u> DATE SIGNED <u>6/16/59</u>	
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR</u>		<u>CAMBRIDGE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Colliotts</u>	22d. LOCATION (City, town, or county) (State) <u>Colliotts, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Hurloughy</u>		24a. REC'D BY REGISTRAR <u>East New Market</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Items 18 Part 1a, 203 to 1; Form 1-1-54 77-727-18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Leon</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tallahassee 44 X-2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Wadde11's Corner</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dorsey</b> Middle Last <b>Johnson</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>About 1914</b>	9. AGE (In years last birthday) <b>About 45 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Tallahassee, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Cora Johnson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>262-32-3065</b>	17. INFORMANT Address <b>Viola Johnson, Vineland, New Jersey</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Delayed, pending complete autopsy report.</b> DUE TO <b>Isopropyl alcohol poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drank rubbing alcohol</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>6/23 1959</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Labor camp shack</b>	20f. (City or town) <b>Hurlock, Dor.</b>	(County)	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>June 29, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Fort Pierce, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom and Son, Federalsburg, Maryland</b>			24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE 

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



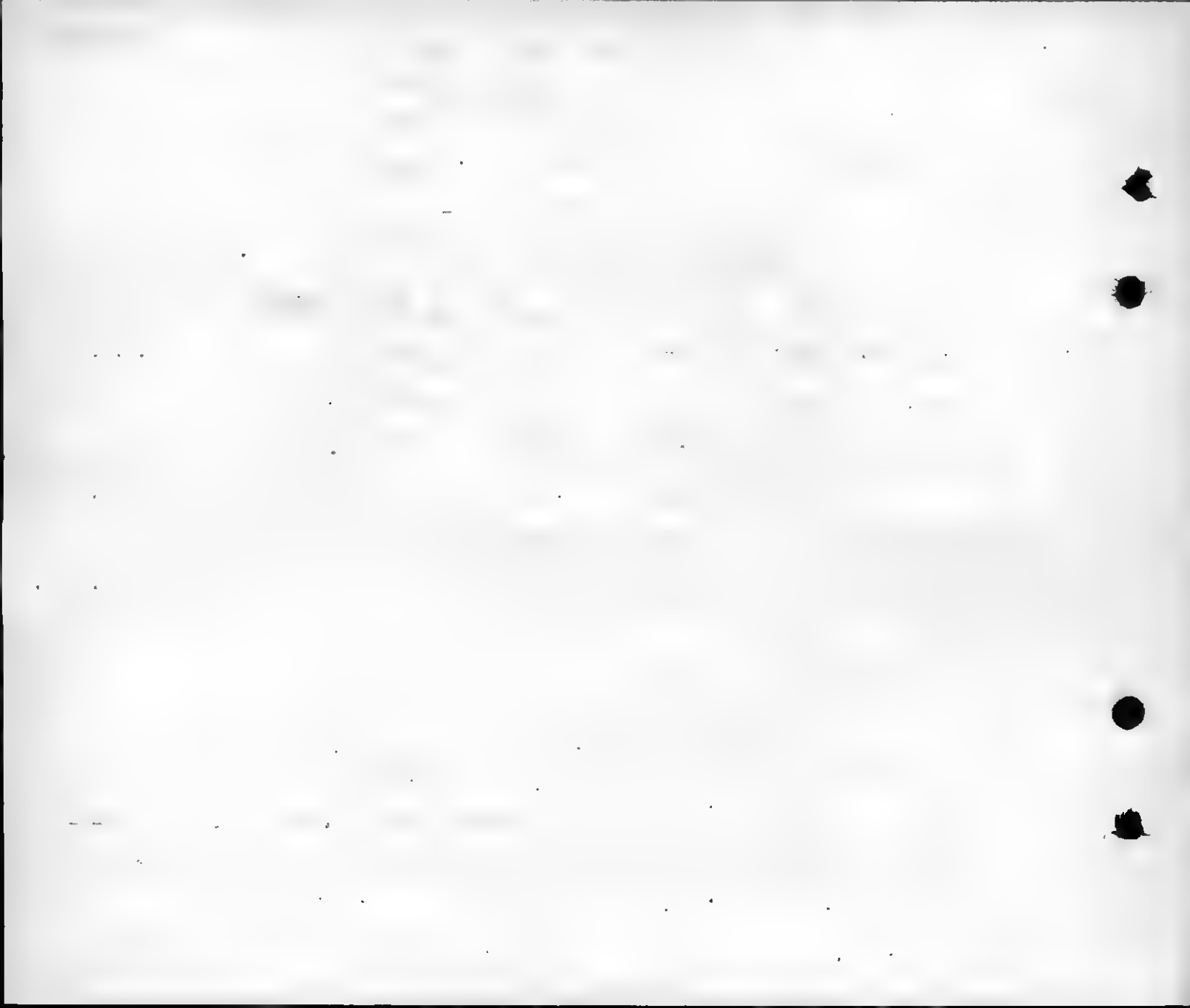
## 6732 CERTIFICATE OF DEATH

06713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1yr 2mo 29days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wittman</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>--</b>			
3. NAME OF DECEASED (Type or print) First <b>Greenbury</b> Middle <b>Dawson</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1876</b>		9. AGE (In years last birthday) <b>82</b> yrs.	F UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed (laborer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Greenbury Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Hunt Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-07-1314</b>		INFORMANT Address <b>RECORDS: Eastern Shore State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) <b>Generalized arteriosclerosis with</b> DUE TO (c) <b>Cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>Sev. yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>March 5</b> , 19 <b>58</b> , to <b>June 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 4</b> , 19 <b>59</b> , and that death occurred at <b>5:30A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Simon Virkutis Eastern Shore State Hospital 6-4-59</b>							
ACTUAL SIGNATURE <b>Simon Virkutis</b>		PHYSICIAN'S NAME (Type) <b>Simon Virkutis Eastern Shore State Hospital, Cambridge, Maryland</b>					
22a. BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
<b>Burial</b>	<b>June 6, 1959</b>	<b>Whit Cemetery</b>	<b>St. Michaels</b>	<b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Hampton Harrison</b>		ADDRESS <b>St. Michaels</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician must sign the certificate. After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6717

Item 15 Film 244 6-22-59 et

## CERTIFICATE OF DEATH

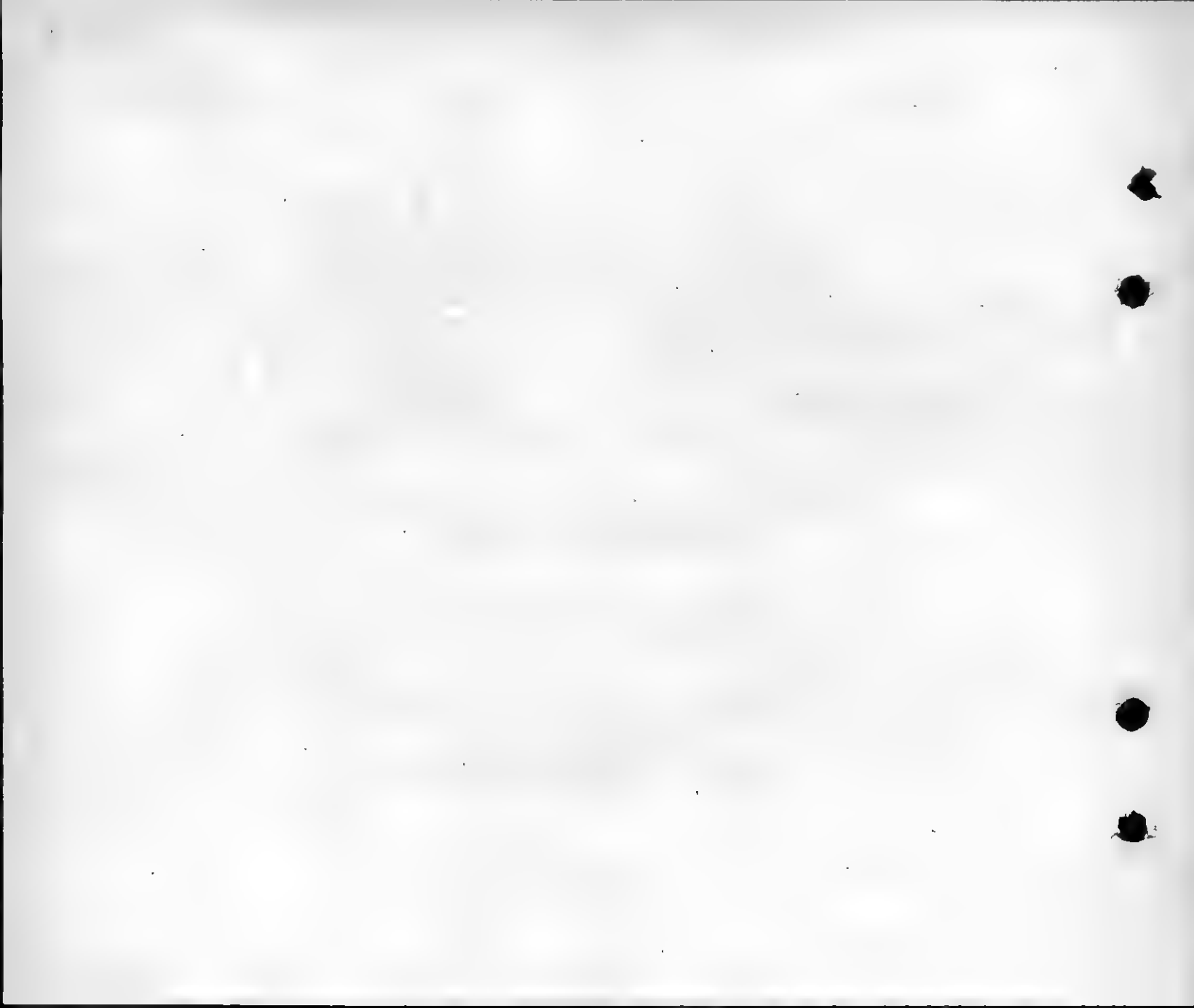
06714

Reg. Dist. No.

1. PLACE OF DEATH a. <b>DORCHESTER</b> b. <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSP,</b>		d. STREET ADDRESS <b>200 SUNBURST HIGH WAY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FRED</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 4 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>12</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LIN E BOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES B JONES</b>		14. MOTHER'S MAIDEN NAME <b>MARY BLADES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>MRS LUCY JONES</b>		Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phlebotrombosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of stomach, intestinal obstruction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 1959</b> to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>6:22 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lewis M. Burdette</b> M.D.		ADDRESS (Street, city or town, state) <b>1 Locust St</b>	
PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b>		Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 14, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEN PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		ADDRESS <b>CAMBRIDGE MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6733

Item 7 Form 24 7-7-59 et

## CERTIFICATE OF DEATH

06715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RFD # and give nearest town) <b>RFD # 3 CAMBRIDGE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Res'dance before admission) a. COUNTY <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RFD # and give nearest town) <b>CAMBRIDGE RFD # 3</b>	
3. NAME OF DECEASED (Type or print) First <b>T</b> Middle <b>JAMES</b> Last <b>KIRWAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>19 59</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>JAN 2 1862</b>
9. AGE (In years last birthday) <b>97</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>CARPENTER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>SHIP CARPENTER</b>	
13. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>UNKNOWN</b>		16. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO. <b>NO</b>	
19. INFORMANT <b>MRS EDWARD MOWBRAY</b>		Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/20</b> , 19 <b>59</b> , to <b>6/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/26</b> , 19 <b>59</b> , and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>104 LOCUST ST CAMBRIDGE MARYLAND</b> DATE SIGNED <b>6/26/59</b> ACTUAL SIGNATURE <b>W. H. HANKS</b> M.D. PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SPEDDENS SEWARDS</b>		22d. LOCATION (City, town, or county) (State) <b>JAMES MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
Address <b>CAMBRIDGE MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



6734

## CERTIFICATE OF DEATH

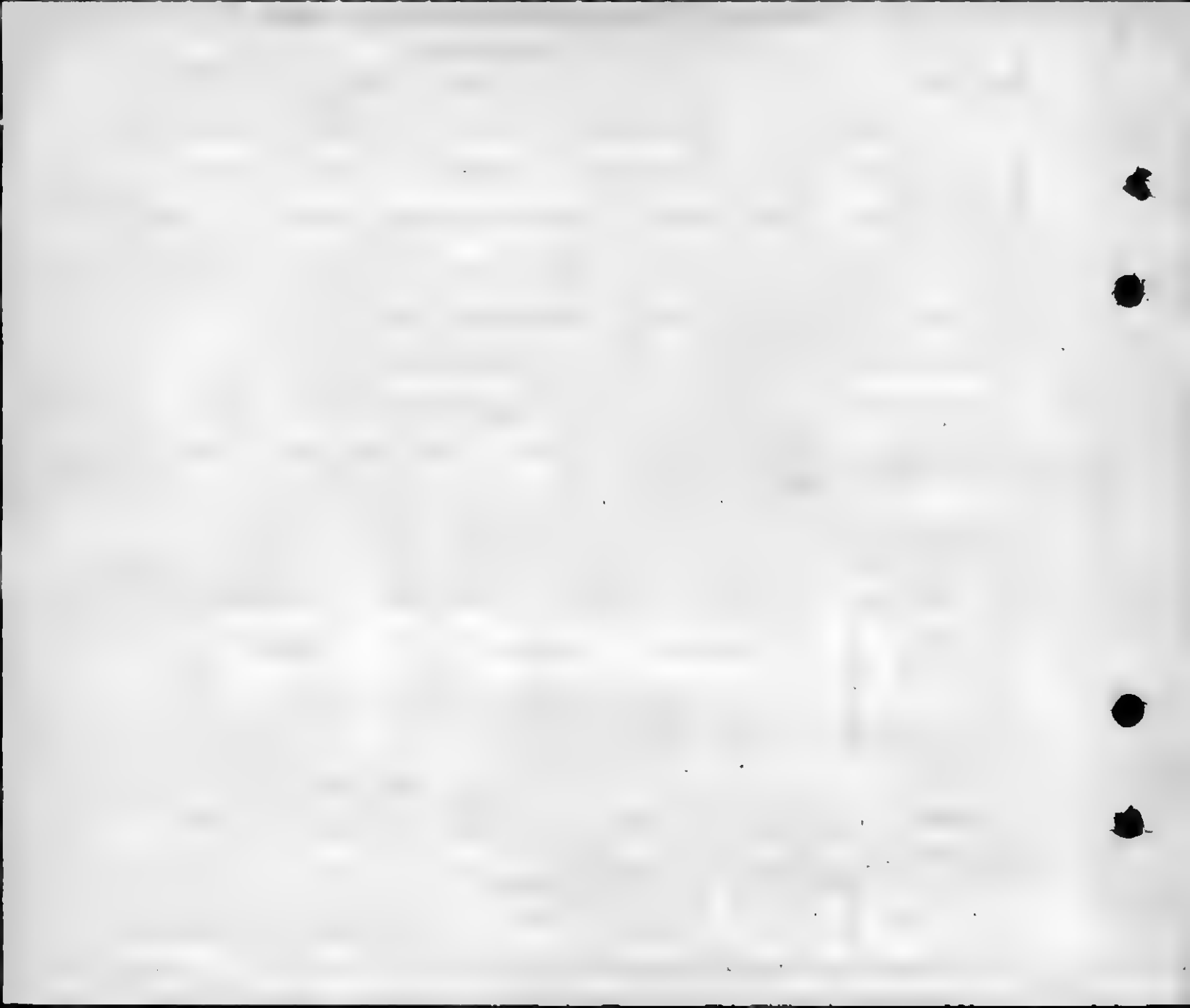
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH FOLSON LYNN</u>		4. DATE OF DEATH Month Day Year <u>JUNE 10 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 18 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN S HILL</u>		14. MOTHER'S MAIDEN NAME <u>EMMA DEAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>180-116-4823</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>AURICULAR FIBRILLATION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>OVER 7 DAYS</u> <u>OVER 7 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILE BRAIN DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 3, 1959</u> to <u>JUNE 10, 1959</u> , that I last saw the deceased alive on <u>JUNE 9, 1959</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D. <u>EASTERN SHORE STATE HOSP. CAMBRIDGE MD. JUNE 10, 1959</u>			
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Crumpton Son</u>		ADDRESS <u>Federalburg Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 16 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thayer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

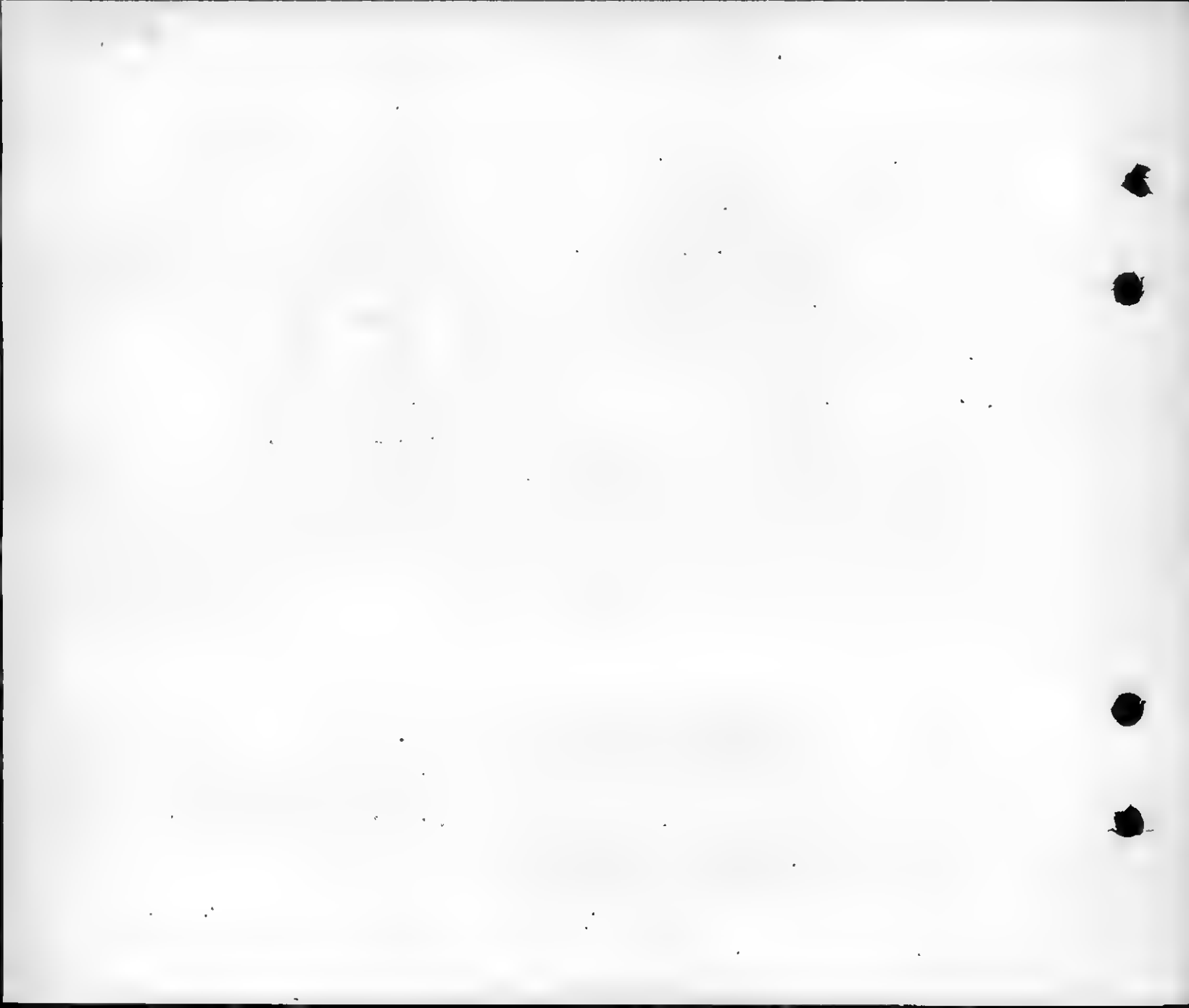
6735

## CERTIFICATE OF DEATH

06759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>4 Mo's</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie Reed Messick</b> First Middle Last		4. DATE OF DEATH <b>June 5 1959</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm Reed</b>		14. MOTHER'S MAIDEN NAME <b>Mahalia Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Eastern Shore State Hospital Cambridge</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 6</b> , 1959, to <b>June 5</b> , 1959, that I last saw the deceased alive on <b>June 5</b> , 1959, and that death occurred at <b>3:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.		E.S.S. Hospital, Cambridge, Md. <b>6-5-59</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 8, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BLOOMERY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>NEAR FEDERALSBURG, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. FRAMPTON &amp; SON, FEDERALSBURG, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>			





FOR STATE  
HEALTH DEPT.

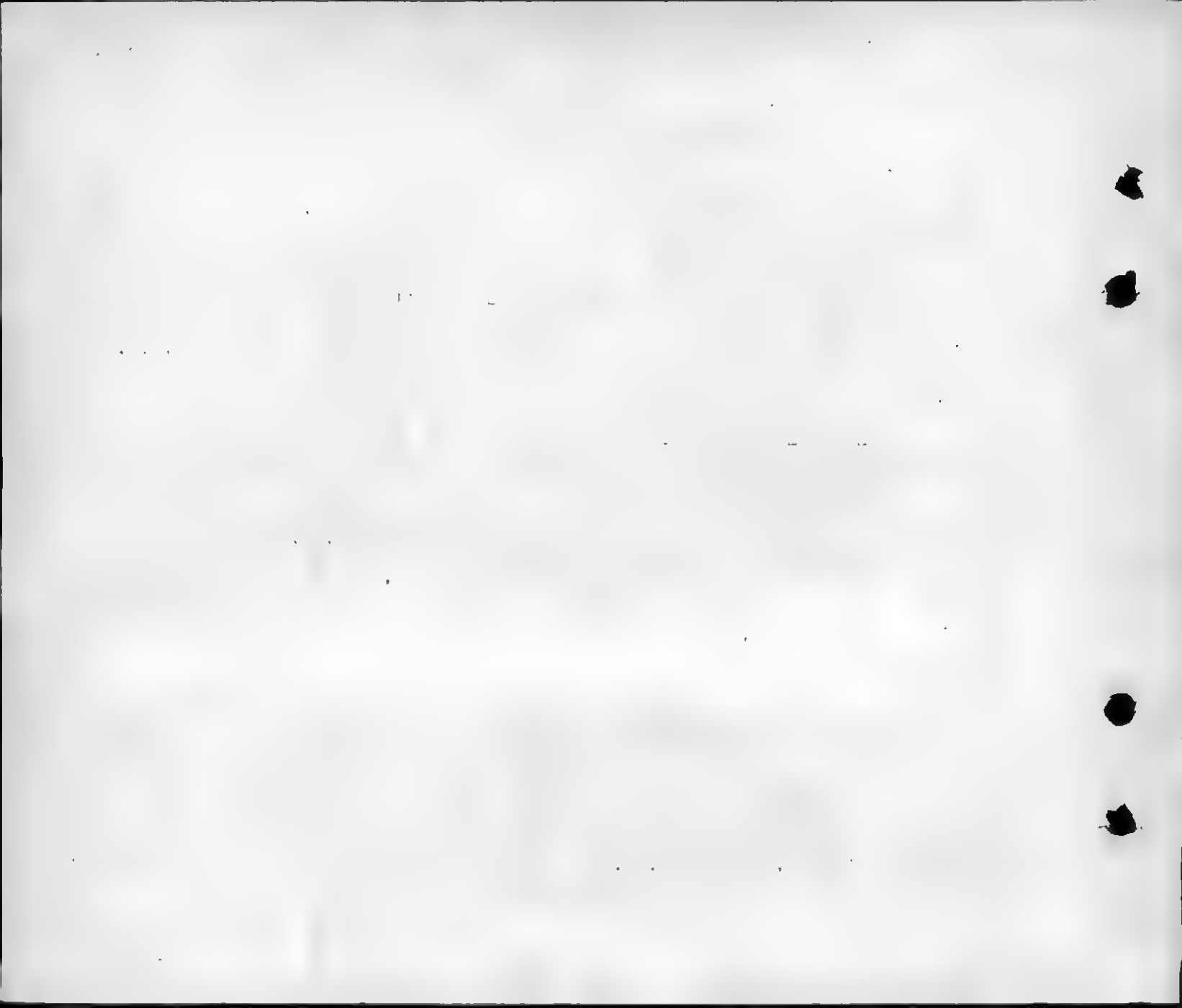
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>103 Elizabeth st.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene Maurice Messick</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 - 13 - 88</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u>	
11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Westley Messick</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>214-30-3743</u>	
17. INFORMANT <u>Records Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic hypertensive C. V. R. Disease</u> DUE TO (c) <u>Fracture, Intertrochanteric Rt, Femur</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain syndrome assoc, with Senile Brain Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Accidental Fall At home</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Accidental Fall At home</u>		20c. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <u>Home</u>	
20d. TIME OF INJURY Month, Day, Year Hour a. m. <u>30 May 59</u> p. m.		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>	
(State) <u>Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff ? M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>7 June '59</u>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Park</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Johnson</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 2 '59</u>	
ADDRESS <u>Salisbury, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6718

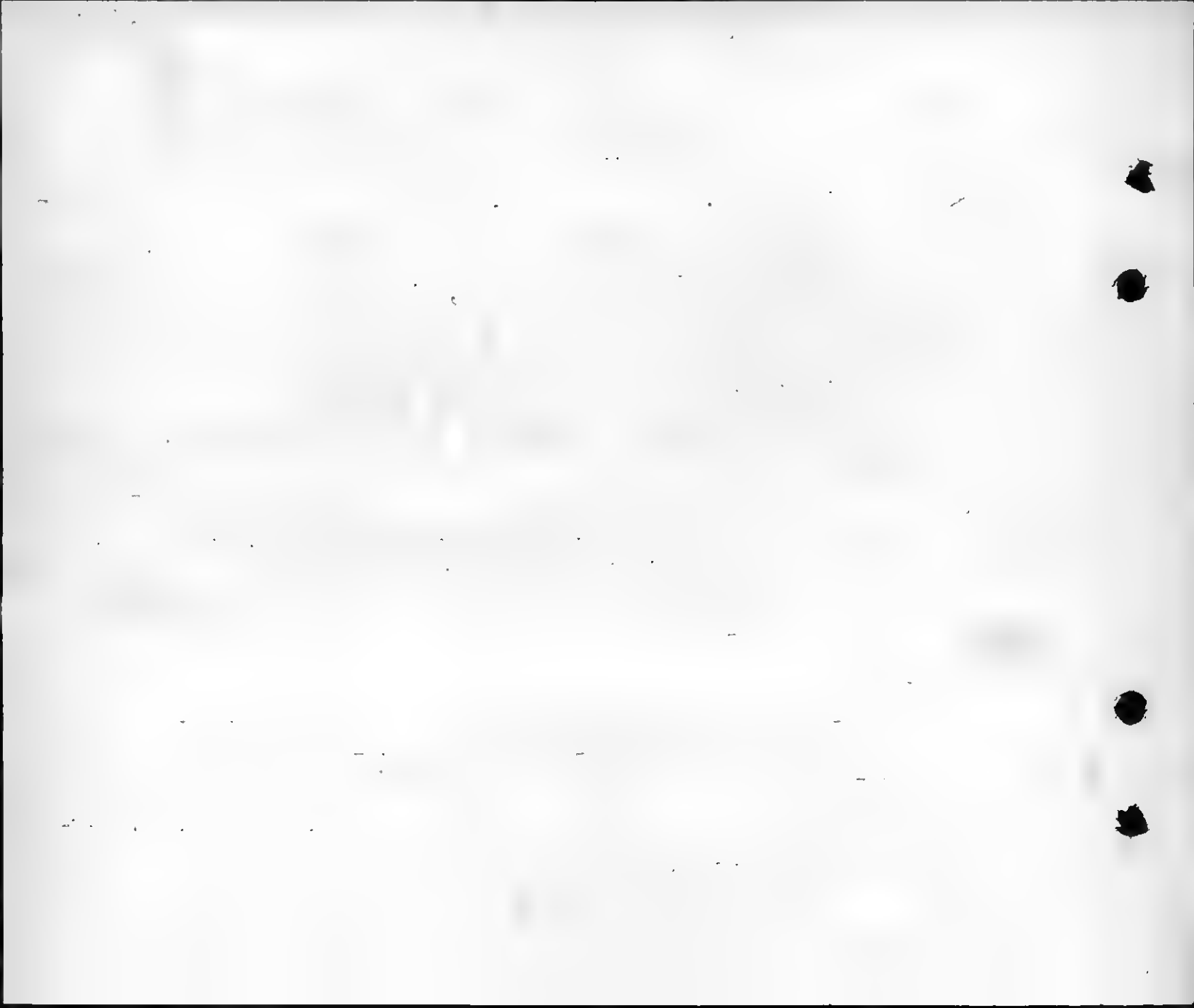
## CERTIFICATE OF DEATH

06718

Reg. Dist. No.

1. PLACE OF DEATH a. <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write full name and nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LYDIA</b> <b>WRIGHT</b> <b>ORR</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 10, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done, if retired, give life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>N EW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM WRIGHT</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N O</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR ***</b>		Address <b>MR JOHN ORR CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442x</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic cardio vascular renal disease</b> DUE TO <b>Generalized carcinomatosis</b> (c) <b>Carcinoma of right breast</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4-5 minutes</b> <b>2 years</b> <b>18 months</b> <b>18 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> p. m. <b>---</b> 19 <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>---</b>		20f. (City or town) (County) (State) <b>---</b>	
21. I certify that I attended the deceased from <b>1-13-58</b> , 19 <b>---</b> , to <b>6-7-59</b> , 19 <b>---</b> , that I last saw the deceased alive on <b>6-7-59</b> , 19 <b>---</b> , and that death occurred at <b>9:05 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>15 Locust Street, Cambridge, Md.</b> DATE SIGNED <b>6-8-59</b> ACTUAL SIGNATURE <b>Eldridge H. Wolff</b> M.D. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 10, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEN PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6719

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		d. STREET ADDRESS <b>508 Trenton street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Albanus</b> Middle <b>Medford</b> Last <b>Paul</b>		4. DATE DEATH <b>June 16, 1959</b> 19	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1909</b>
9 AGE (In years last birthday) <b>49</b> yrs		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taylor's Island</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Paul</b>		14. MOTHER'S MAIDEN NAME <b>Myra Wallace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-6717</b>	
17. INFORMANT <b>Mrs. Bertha G. Paul</b>		Address <b>508 Trenton St., Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerotic cardio vascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 mins.</b> <b>20 mins.</b> <b>1 year</b>
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-16</b> , 19 <b>58</b> , to <b>6-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-16-59</b> , 19 <b>59</b> , and that death occurred at <b>12:30 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Eldridge H. Wolff</b> M.D. <b>15 Locust Street, Cambridge, Md. 6-16-59</b> SIGNATURE NAME (Type) <b>Eldridge H. Wolff, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel R. H. H. H.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6737

## CERTIFICATE OF DEATH

06720

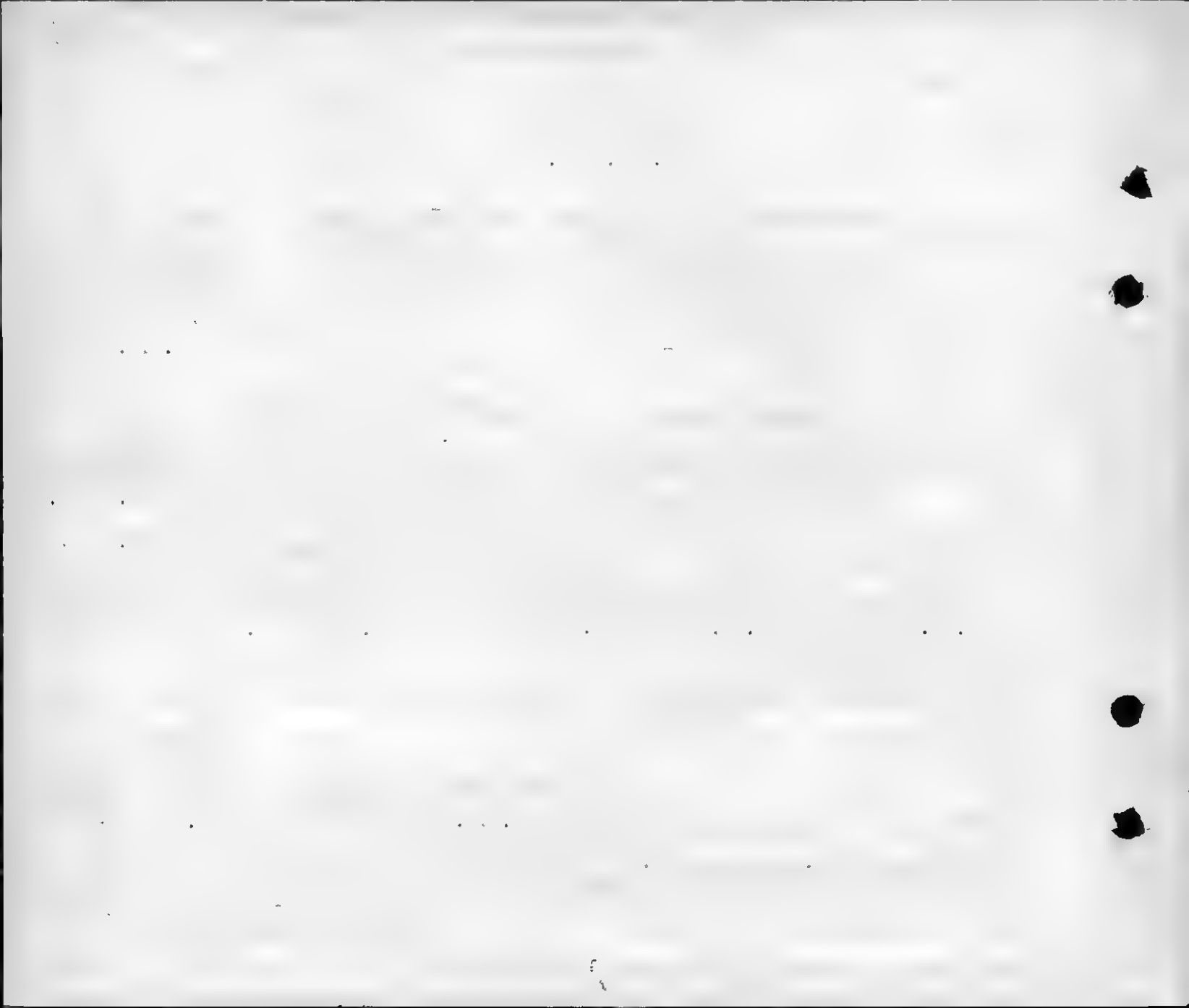
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Pierce</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-69</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Penn Shade</u>		14. MOTHER'S MAIDEN NAME <u>Mary Southerland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch.Br.Syndrome Assoc. W. Smile Br. Disease, With Psy. Reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sev. yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 26, 1955</u> , to <u>June 24, 1959</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>59</u> , and that death occurred at <u>2:25 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Currier</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6-24-59</u>	
PHYSICIAN'S NAME (Type) <u>George E. Currier, M.D.</u>		M.D. <u>E.S.S. Hospital, Cambridge, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brock View Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas M. Miller</u>		ADDRESS <u>Rising Sun Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 26 59</u>		24b. REGISTRAR'S SIGNATURE <u>Colbert A. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





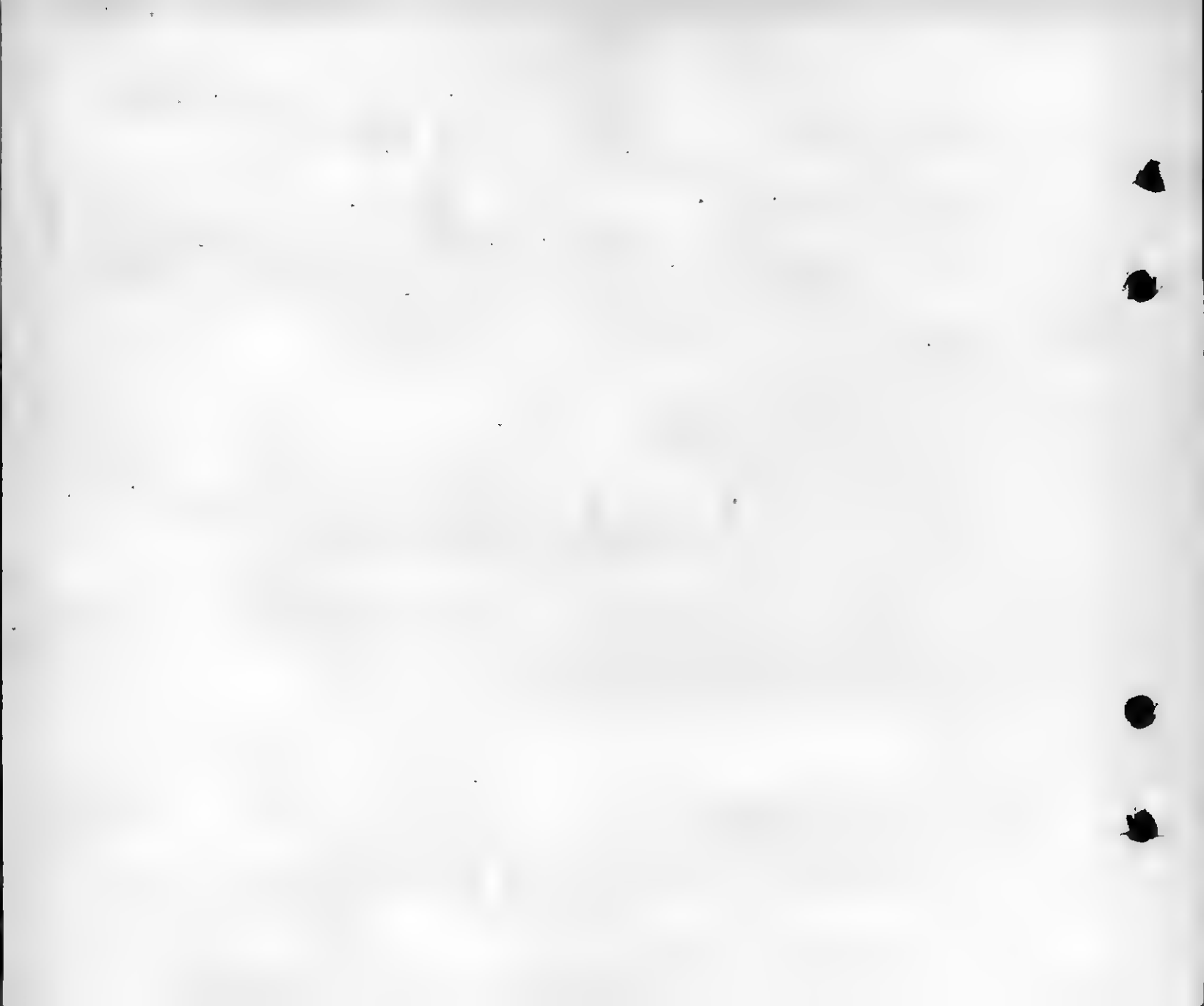
6720

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write nearest town) <b>CAMBRIDGE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
c. LENGTH OF STAY IN 1b <b>3 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOPS HEAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSP.</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>SULLENDER</b> Last <b>RUARK</b>		4. DATE OF DEATH Month <b>JUNE 11</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 24 1885</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during preceding 12 months, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN P SULLENDER</b>		14. MOTHER'S MAIDEN NAME <b>MARY PRITCHETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR RICHARD C RUARK</b>		Address <b>BISHOPS HEAD MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diabetic Mellitus</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>7</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5:10</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/10</b> 19 <b>59</b> to <b>6/11</b> 19 <b>59</b> that I last saw the deceased alive on <b>6/11</b> 19 <b>59</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. HANKS</b>		DATE SIGNED <b>6/11/59</b>	
PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>		ADDRESS (Street, city or town, state) <b>104 Locust St CAMBRIDGE MARYLAND</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 14 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEN PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	
ADDRESS <b>CAMBRIDGE MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6738

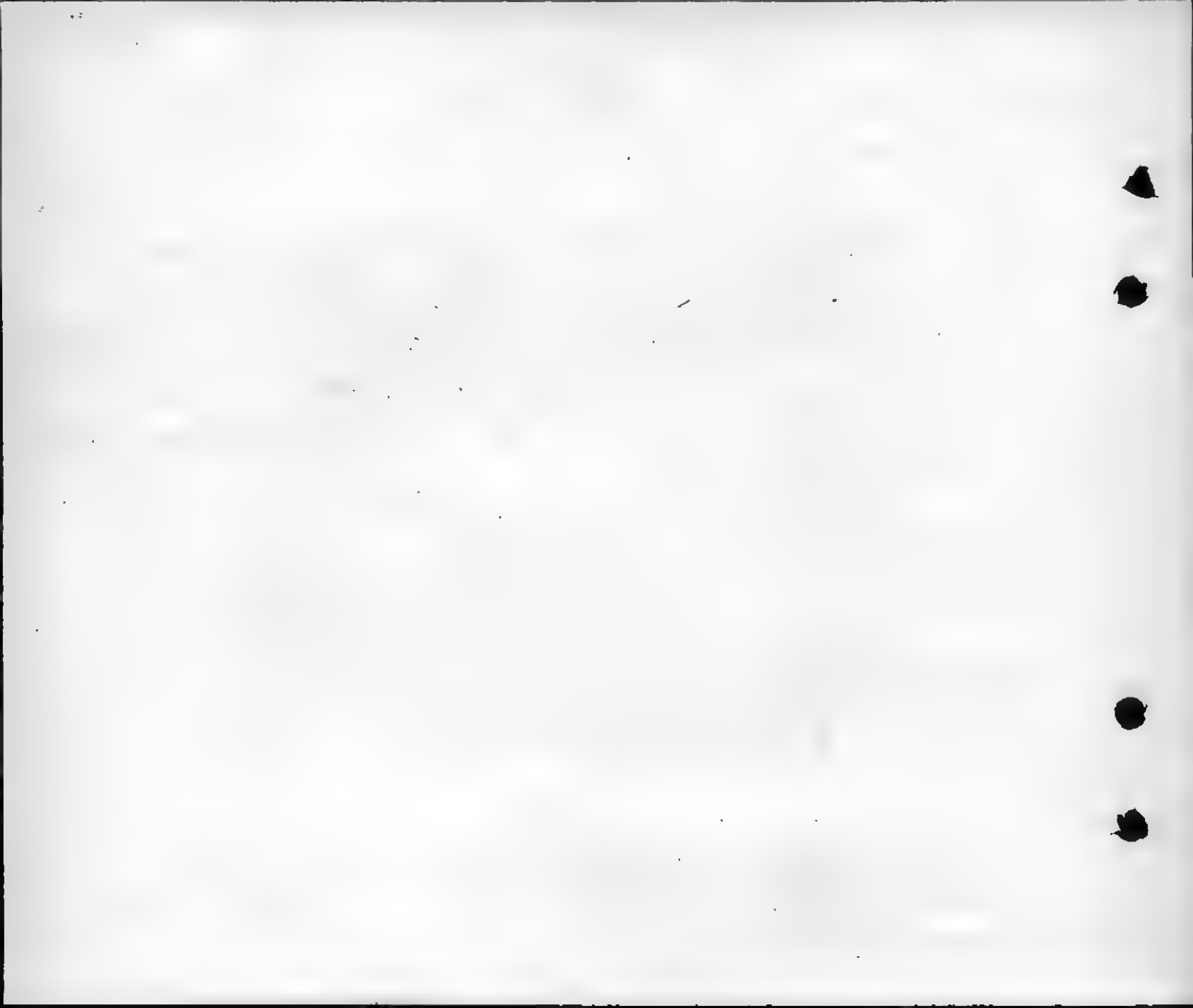
CERTIFICATE OF DEATH

06723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHURCH CREEK</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNIE</b> First <b>JONES</b> Middle <b>STEWART</b> Last		4. DATE OF DEATH Month <b>JUNE 29</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 10, 1878</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last year, or working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN JONES</b>		14. MOTHER'S MAIDEN NAME <b>SARAH LINTHICUM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS W H HARRISON</b> Address <b>CHURCH CREEK MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>und</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>und</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/14</b> , 19 <b>59</b> , to <b>6/29</b> , 19 <b>59</b> that I last saw the deceased alive on <b>6/28</b> , 19 <b>59</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 RACE ST. CAMBRIDGE, MD</b> DATE SIGNED <b>7/1/59</b> ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D. PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV CAMBRIDGE, MD</b>			
22a. BURIAL OR CREMATION, (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JUNE 1 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OLD TRINITY</b>	22d. LOCATION (City, town, or county) (State) <b>CHURCH CREEK MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPTE FUNERAL SERVICE</b> ADDRESS <b>CAMBRIDGE MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6739

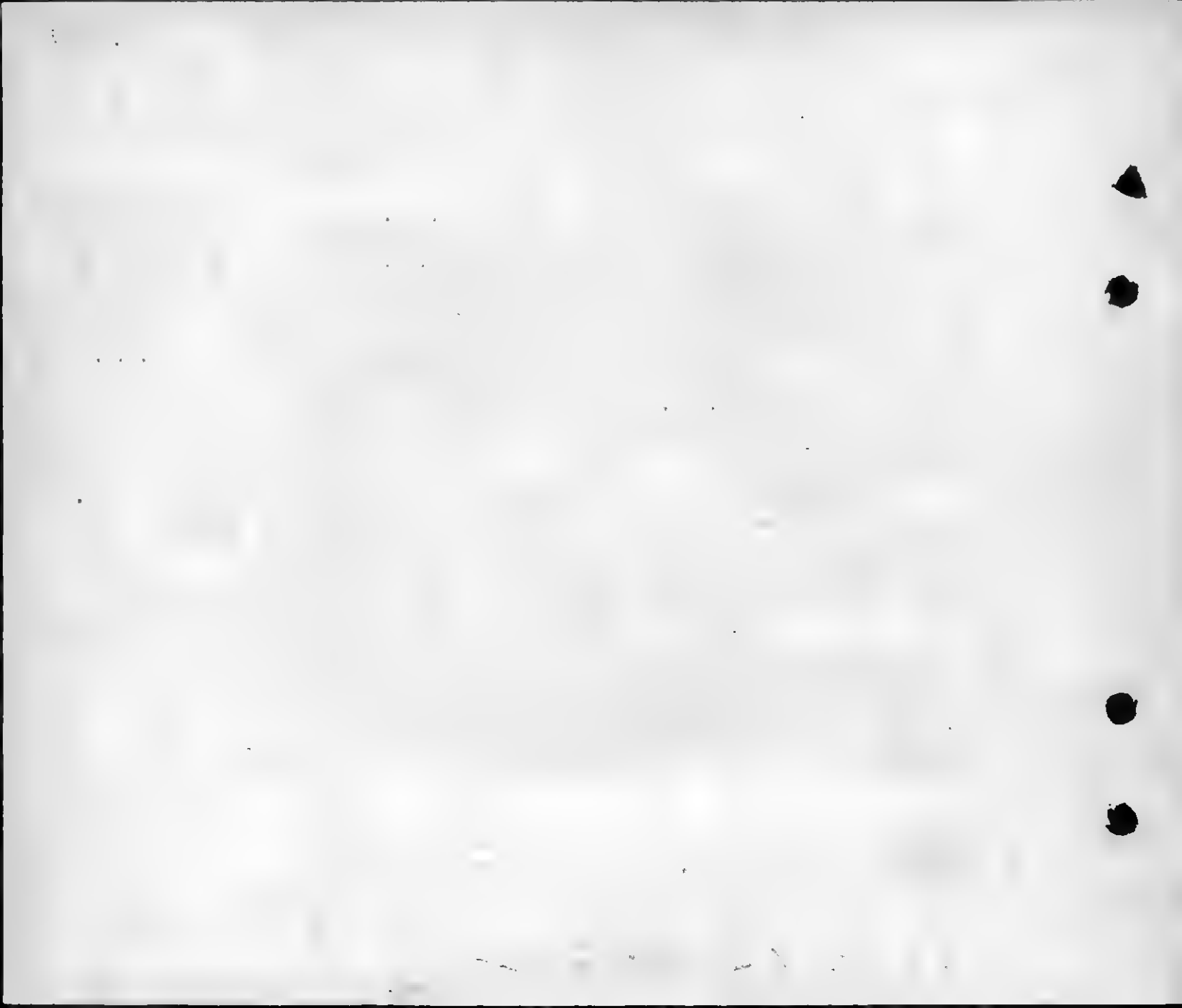
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN TB <b>15yr 6mo 24days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>			d. STREET ADDRESS <b>R.F.D. # 2</b>		
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Oliver</b> Last <b>Taylor, Jr.</b>			4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1920</b>		9. AGE (In years last birthday) <b>39</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Clarence Oliver Taylor, Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Burleigh Newman</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		
16. SOCIAL SECURITY NO. <b>--</b>			17. INFORMANT <b>RECORDS: Eastern Shore State Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6.15.59 U. of Md. Med. School</b>			22b. DATE THEREOF <b>6/12/59</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Md.</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>			24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		
			24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 should be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6721

## CERTIFICATE OF DEATH

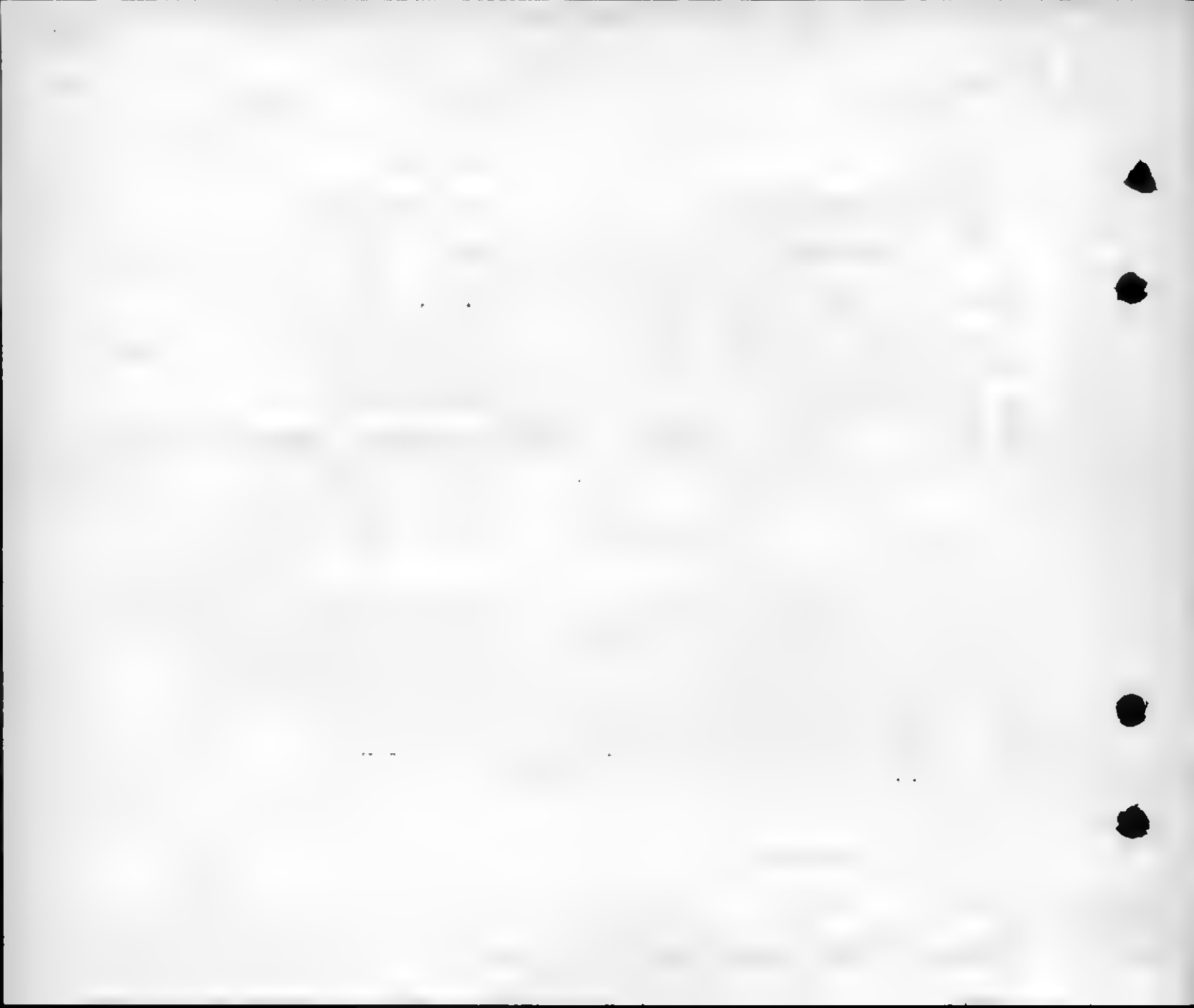
06725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> c. LENGTH OF STAY IN lb <b>2 WEEKS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GLASGOW NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> d. STREET ADDRESS <b>404 SPRINGHILL AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH HAYES TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>JUNE 9 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>N OV. 15, 1886</b>
9. AGE (In years last birthday) <b>72</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>TAYLOR HAYES</b>		14. MOTHER'S MAIDEN NAME <b>JOEPHINE SHORTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>UNKNOWN</b>	
17. INFORMANT <b>MR THURMAN SHORTER</b>		Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO <b>Hypertension Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Vascular Disease</b> (c) <b>Hypertension Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>274X</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-20-58</b> , 19____, to <b>6-9-59</b> , 19____, that I last saw the deceased alive on <b>6-9-59</b> , 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Albert E. Bunker, M.D. 200 Maryland Ave.</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M.D. Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, OR OTHER (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 12, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		ADDRESS <b>CAMBRIDGE MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. B. Bunker</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06726

Item 9 Film 6244 7-14-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> c. LENGTH OF STAY IN 1b <b>Cambridge, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> d. STREET ADDRESS <b>222 High St.</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Lee Tillery</b>		4. DATE OF DEATH <b>June 21 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1885</b>
9. AGE (In years last birthday) <b>73 7/4</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dudley Tillery</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Tillery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>216-40-4638A</b>	
17. INFORMANT <b>Mrs. Robert Tillery</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma colon</b> DUE TO (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>153.8</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/24/59</b>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>		DATE SIGNED	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Dorchester, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Clair Funeral Home</b>		24. REG'D BY REGISTRAR <b>JUL 6 59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PMG. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 244 7-20-59 et

## CERTIFICATE OF DEATH

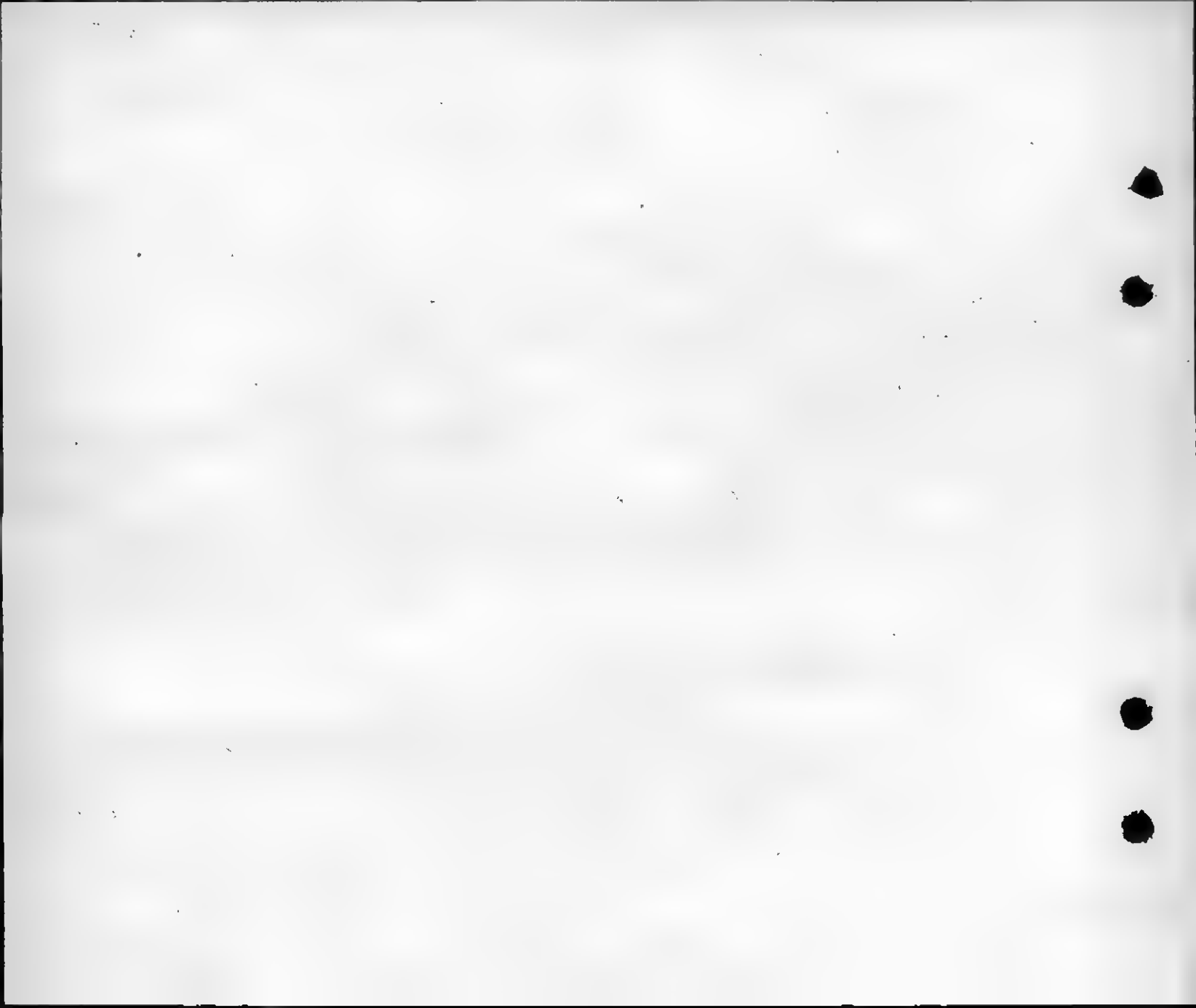
06727

Reg. Dist. No.

6723

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> c. LENGTH OF STAY IN 1b <b>3 HOURS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE <b>CAMBRIDGE MARYLAND HOSP.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> d. STREET ADDRESS <b>204 WEST END AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>F</b> Last <b>TOLSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. <del>MARRIED</del> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1879</b>
9. AGE (in years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO &amp; OHIO RR CO</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM TOLSON</b>		14. MOTHER'S MAIDEN NAME <del>Laura</del> <b>LAURA ROBBINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS GEORGE BENNETT</b>		Address <b>CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Artery Thrombosis</b> 4001 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/4</b> 19 <b>59</b> to <b>6/7</b> 19 <b>59</b> . That I last saw the deceased alive on <b>6/7</b> 19 <b>59</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Hanks</b> M.D.		ADDRESS (Street, city or town, state) <b>104 Locust St CAMBRIDGE Md</b>	
PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>		DATE SIGNED <b>6/8/59</b>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 10, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SPEDDENS CEMETERY</b>		22d. LOCAT ON (City, town, or county) (State) <b>HUDSON MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b> ADDRESS <b>CAMBRIDGE MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6724

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write street and nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN IL <b>USA 6 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSP</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL M TYLER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 12 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	9. AGE (In years last birthday) <b>83 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN TYLER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA MEEKIN S</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ACKLEY TYLER FISHING CREEK</b>		Address <b>MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>446X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Nephritis</b> (c) <b>Chr. Nephritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/12</b> , 19 <b>59</b> , to <b>6/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/14</b> , 19 <b>59</b> , and that death occurred at <b>4 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Hanks, M.D.</b>		ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge Md</b>	
PHYSICIAN'S NAME (Type) <b>W. H. Hanks, M.D.</b>		DATE SIGNED <b>6/15/59</b>	
22a. BURIAL-CREMATATION, (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JUNE 18, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOOSIER MEMORIAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>FISHIN G CREEK MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPT FURNAL SERVICE</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06729

Reg. Dist. No.

1. PLACE OF DEATH <b>DORCHESTER</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>CAMBRIDGE</b>	c. LENGTH OF STAY IN lb <b>3 HOURS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 CAMBRIDGE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NATIONAL CAN CO</b>		d. STREET ADDRESS <b>116 ACADMEY STREET</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MILFORD</b> Middle <b>PAUL</b> Last <b>WEBSTER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12,</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 21 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done or (A) (B) (C) in waiting list, when required) <b>MILFORD AL CAN CO</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN WEBSTER</b>	
14. MOTHER'S MAIDEN NAME <b>LENA EWELL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>UNKNOWN</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214 07 8210</b>		17. INFORMANT Address <b>MRS HELEN WEBSTER CAMBRIDGE MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic C-V disease.</b> (c) <b>?</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		DATE SIGNED <b>6/13/59</b>	
22. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>JUN 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEN PARK</b>	22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPTE FUNERAL SERVICE CAMBRIDGE MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. K. K.</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

